Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 14 April 2016**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

SUPPLEMENTARY AGENDA

Item 7. **Service in A&E following attempted suicide or self-harm episodes**

Appendix C – report from James Paget University Hospitals NHS Foundation Trust **(Page A3)**

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Date Supplementary Agenda Published: 8 April 2016

IN TRAN communication for all	**If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact Tim Shaw on 0344 800 8020 or Textphone 0344 800 8011 and we will do our best to help.**

James Paget University Hospitals NHS
NHS Foundation Trust

SELF HARM UPDATE FOR NHOSC REPORT - April 1016

MENTAL HEALTH SERVICE PROVISION

NSFT currently have a CQUIN in place to provide an interim Liaison Psychiatric Service to James Paget Hospital, 7 days a week. Hours of service are currently between 9.30 - 00.00. The service is established for a Band 6 RMN Practitioner and a Band 4 support worker. The service currently provides robust specialist support for the A&E department by providing comprehensive mental health assessments and appropriate signposting to specialist mental health services.

This service has proved invaluable and provides a much improved quality patient experience for this vulnerable patient group, ensuring they gain rapid access to the appropriate health care professionals. In addition the A&E staff themselves have felt supported and have gained in confidence when managing this often challenging area of their work.

The Practitioners are also tasked with targeting a cohort of frequent attenders with mental health issues and known to NSFT services, to offer access to alternative support systems with the objective of avoiding admissions to A&E. There is recognition however, that this cohort of patients often adopt a chaotic lifestyle and fail to engage on a regular basis with support services.

In addition, we receive input from the Youth Team at Band 6 and Band 4 at James Paget Hospital,, both on Ward 10 (Children & Young Persons Unit) and in A&E, Monday – Friday , with clinics on a Saturday and Sunday morning. We also have a service level agreement with NSFT that all patient referred to the Community Crisis Support Team will have a response time within 4 hours.

Due to on-going staffing and funding issues at NSFT, this has sometimes proved problematic to achieve, with the result that the service response has been erratic, particularly at night, thus causing sometimes unacceptable delays for patients requiring a mental health assessment in a timely fashion, resulting in long waits in A&E.

However as an Emergency Department we have established good collaborative working with NSFT where issues when raised are taken seriously and action taken where necessary.

EDUCATION & TRAINING

As part of the Mental Health CQUIN, NSFT were commissioned to provide a series of bespoke teaching sessions for A&E staff both medical and nursing. Sessions took place in the A&E Department and were delivered by an experienced member of the Education team. The sessions provided a comprehensive overview of common mental health issues to include addiction and self –harm. The sessions have been extremely well received by A&E staff and have proved invaluable in raising awareness and understanding of this complex group of patients.

In addition , the Trust has organised with NSFT via our Education Department for a Mental Health Teaching Programme to be delivered over the next 12 months available to all health care professionals.

POLICY UPDATE

James Paget has a robust Self Harm Policy in place . The policy is due for revision in June 2016. (Appendix 1)

There was an amendment in February 2016 to the transfer policy which is included here.

As a further response to concerns relating Self Harm, the Trust has commissioned an Enhanced Supervision Policy, ratified in April 2016 (Appendix 2) for those patients at risk of self- harm as a result of challenging behaviour, lack of mental capacity & refusing to accept essential medical treatment.

James Paget University Hospitals NHS
NHS Foundation Trust

Self-Harm Management Policy

Document Control:

Document Author:	**Justine Goodwin, Senior Sister, Paediatrics Jacky Copping, Deputy Director of Nursing**		
Document Owner:	**Document Review Group**		
Electronic File Name:	**Self-Harm Management Policy (Adult & Paediatric) dated June 2013**		
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Version	Date	Author	Reason
V1.0	June 2013	Justine Goodwin, Jacky Copping	To originate document
V1.1			
V1.2			
V1.3			
V1.4			
V1.5			

EXECUTIVE SUMMARY

Self-harm is a predictable indicator of suicidal intent and is often the result of a series of complex risk factors and personal events. The impact of suicide is devastating for family members and friends and has a bearing on many other aspects of society. The prevention of suicide is multifaceted and all healthcare organisations should have in place strategies to effectively manage patients presenting with self-harm. Pathways should be developed using a patient centered, risk based approach.

CONTENTS

1.0 INTRODUCTION

1.1 Background

Self-harm is considered a reliable indicator of suicide risk. It is estimated that people who self-harm are more after and 100 times at risk of suicide than the general population (Mental Health Network NHS Confederation 2011). In recent years the drive to reduce incidents of suicide by early detection and treatment from all across all sectors has become better recognised (DoH 2012). This includes the development of various national and local frameworks/tools to support local implementation of suicide prevention strategies.

The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness Annual Report (2012) reported that the most common methods of suicide were hanging/strangulation, self-poisoning (overdose) and jumping from heights. The prevalence of suicide is higher in males than females and although the report demonstrated a gradual decrease in the number of for all suicides (age 10 and above) recorded between 2000 and 2010, the overall incidence was recorded at 4021. Incidence of hanging also increased compared to decreases in other methods of suicide.

There are also close links between self-harm and personality disorders. Other diagnoses such as major depressions, anxiety disorders, eating disorders, substance misuse are also at higher levels of risk (Royal College of Psychiatrists 2010) and as such require a consistent approach to assessment and treatment pathways.

1.2 Scope

The scope of this policy is Trust wide and relates to a framework of care delivery for the management of patients who have a current or previous clinical presentation of self-harm, either as an A&E attendee or those receiving inpatient care at the Trust. The policy includes adult and paediatric patients.

The policy incorporates the relevant standards from within NICE Clinical Guideline No: 16- Self Harm, The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (2004).

The Policy applies to all medical staff, nursing staff, allied health professionals and relevant support workers, including the interface between secondary and primary care services.

1.3 Responsibilities

Executive Directors
As accountable officers, the Executive Team must ensure that responsibility for identification and assessment of risks associated with self-harm are correctly delegated and that safe systems of work, based on national guidance and best practice, are used to direct practice and ensure the highest standard of quality and safety are delivered to patients presenting with self-harm.

Clinical Leads, Matrons and Ward Managers
Clinical Leads, Matrons and Ward Managers are responsible for:
the dissemination of this policy to their staff
conducting risk assessments, implementing, monitoring and evaluating risk reduction actions (appendix 1&2)
ensuring that clinical environments are conducive to patient safety and that adequate and safe staffing levels are maintained
the implementation and monitoring of practice standards within the policy
identifying any theory/practice gaps and accessing training for their staff including Mental Capacity Act

facilitating the release of staff to attend training
using effective strategies to communicate issues relating to patients who are at risk of self-harm
ensuring links to support services e.g. crisis teams are known and easily accessible
putting in place actions to ensure that appropriate risk assessments are undertaken, implemented, monitored and evaluated
supporting staff who care for patients who self-harm e.g. via clinical supervision
initiate, undertake and participate in appropriate investigations
promote clinical environments that demonstrate respect and dignity for patients who self-harm
demonstrating compliance with Trust and Professional documentation/record keeping policy requirements

All Clinical Staff
All clinical staff, regardless of whether they are permanent, locum, contracted or agency, have a responsibility to;
understand and apply the principles of this policy
be appropriately trained to make accurate risk assessments of patients who have, or who are at risk of self-harm with full, involvement of the patient
be appropriately trained to make accurate risk assessments of the environment where patients at risk of self-harm are cared for
conduct risk assessments, implement, monitor and evaluate risk reduction actions
highlight and escalate concerns relating to the ability maintain patient or staff safety
effectively deal with emergency situations involving patients at risk of self-harm
make clear, concise and accurate records
communicate information relating to risk control measures and specific care and treatment plans to relevant co workers
consider the Mental Capacity Act when dealing with patients who self-harm particularly in relation to consent to treatment
maintain their own safety and that of others
accurate communication and risk assessment when patients are transferred from ward to ward
demonstrating compliance with Trust and Professional documentation/record keeping policy requirements

Patient Flow Team
The Patient Flow Team are responsible for ensuring that all individual patient and environmental risks have been considered prior to allocating patients from A&E to a general ward area.

1.4 Monitoring and Review

This policy will be reviewed every three years unless best practice evidences changes or legislative changes supersede the review date.

The policy will be monitored by using the Preventing Suicide – A toolkit for emergency departments (Mental Health Network NHS Confederation 2012). The Emergency Division will responsible for developing and undertaking an audit of these standards on a bi annual basis. All Divisions will be responsible for performing two random case note reviews per year as part of their Annual Audit Plan (including Paediatrics). The case note reviews will be based on NICE standards as outline in 'Self Harm', Clinical Guideline 16.

1.5 Related Documents

- National Institute for Clinical Excellence issued Clinical Guideline: No.16- Self Harm - The short term physical and psychological management and secondary prevention of self-harm in secondary care. http://www.nice.org.uk/nicemedia/pdf/CG16FullGuideline.pdf

- Preventing Suicide – A toolkit for emergency departments (2012), Mental Health Network NHS Confederation http://www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-emergency-departments.pdf
- Preventing suicide in England – A cross-government outcomes strategy to save lives (2012) HM Government
- Royal College of Psychiatrists(2010)www.rcpsych.ac.uk/
- Mental Capacity Act (2005)
- National Patient Safety Agency, Preventing suicide - A toolkit for mental health services (NPSA 2009) http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65297
- Children and Young People under the Age of 16 Years who Abscond/Go Missing from the Paediatric Ward – Management
- Missing Persons Guidance
- Chaperoning Policy
- Restraint Policy
- Physical restraint on Patients in Intensive Care and the Acute Setting Policy and Procedure
- Consent Policy
- Safeguarding Children
- Safeguarding Adults – Vulnerable Adults in need of Protection

1.6 Reader Panel

The following formed the Reader Panel that reviewed this document:

Post Title
Senior Sister, Paediatric
Matron, Emergency Division
Assistant Director of Governance and Compliance
Estates Manager
Emergency Care Consultant
Deputy Director of Nursing, Quality & Safety
Local Security Management Specialist and Emergency Planning Manager

1.7 Trust Values

This Policy conforms to the Trust's values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

1.8 Glossary

Term	Definition
Self-harm	self-poisoning or self-injury, irrespective of the apparent purpose of the act
Positive Risk Taking	A person centred approach focussing on the service users strengths and support required to enable them to take control of their behaviour
Paediatric	a patient aged below 16 years
Young Person	a patient between 11 and 18th birthday
Adult	a patient age 18 and above
CAMHS	Children & Adolescent Mental Health Services

The following terms and abbreviations have been used within this Policy:

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

2.0 STATEMENT OF POLICY

All patients presenting to the Trust requiring care related to self-harm and associated suicide risk will receive individualised care using a risk based approach using national guidance and current best practice, and in accordance with this policy.

2.1 Policy Objectives

The objective of the Policy is to:

- Set out the minimal standards of care for patients who self-harm
- Reduce the risk of self-harm injuries and suicide attempts by patients using the Trust
- Provide clarity between paediatric and adult pathways
- Ensure appropriate coordination happens between secondary care and primary/tertiary care services

2.2 Policy Definitions

This Policy uses the definition of self-harm, from the NICE Clinical Guideline, No. 16 (2004) which is "self-poisoning or self-injury, irrespective of the apparent purpose of the act". Para-suicide is considered "an act with non-fatal outcome, in which the individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences".

It has been generally accepted that the words "deliberate" or "intentional" to pre-fix self-harm and "commit" to prefix suicide have a negative effect and are not acceptable to service users, and in view of this these words should be avoided by staff.

3.0 MANAGEMENT OF PATIENTS WITH SELF HARM

People who self-harm need to be treated with the same respect and understanding given to others who use the health service, taking account of their physical and emotional distress; their needs for support and information; and their right to be properly involved in clinical decision-making. Healthcare professionals caring for patients who have self-harmed must be able to understand and assess mental capacity in order to ensure that appropriate processes are followed prior to any treatment being initiated.

NICE (2004) define broad principles that all services should meet and include the key aims and objectives of the treatment of self-harm.

- Referral for further assessment and/or treatment should be based upon a comprehensive assessment
- Rapid assessment of physical and psychological need, irrespective of the venue
- Effective engagement of the patient, relatives and carers
- Effective measures to minimise pain and discomfort
- Timely initiation of treatment
- Harm reduction
- Rapid and supportive psychosocial intervention
- Prompt and effective psychological and psychiatric treatment where indicated
- An integrated and planned approach to the persons problem

3.1 Patient Safety

3.1.1 Patient Assessment and Referral to Support Services

For all patients the level of injury sustained from self-harm will determine the speed of initial assessment. Tools such as TOXBASE and the National Poisons Information Service are available (in A&E) at all times as an information resource to support effective and timely treatment interventions. Specific evidence based interventions e.g. use of activated charcoal must be documented accordingly in the healthcare record.

Unless lifesaving or immediate interventions are required to reduce the risk of deterioration, the general assessment principles will be to perform basic psychosocial risk assessment should include the identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, in particular, depression, hopelessness and further suicidal intent. These include;

- social situation (including living arrangements, work and debt)
- personal relationships (including recent breakdown of significant relationships)
- recent life events and current difficulties
- psychiatric history and mental state examination, including any history of previous self-harm and alcohol or drug use
- enduring psychological characteristics that are known to be associated with self-harm
- motivation for the act
- long-term vulnerability factors
- short-term vulnerability factors
- precipitating factors

Staff also need to recognise:

- the addictive /compulsive nature of self-harm and be prepared to discuss this with the patient
- patient who self-harm can very quickly become distressed or volatile during consultations, and have strategies in place to deal with this
- the need for a consistent approach to the management of people who self-harm

- the involvement of third parties e.g. Mental Health Crisis Teams or Police in the care of patients who self-harm will be determined on a case by case basis following individual assessment documented as such in the patients healthcare record.

All assessment processes and outcomes will be documented and filed in the relevant healthcare record (i.e. electronic or paper). Patients not previously known to the Trust as a self-harmer may have limited information available however; it is the responsibility of the staff member completing the assessment to gain as much information as possible from the available sources to aid in the recognition and management the self-harm injuries and on-going health care needs. Wherever possible this should be a joint process with the patient to demonstrate involvement in the decision making process however with the patients consent this may include information available from relatives and carers.

In cases where language barriers exist interpreter services must be accessed using agreed processes as outlined in the Trust policy 'Accessing an interpreter including the use of INTRAN'. Relatives and carers must not be used as a substitute.

For all patients who have been assessed to be at risk of self-harming behaviour there will be an agreed plan in place as to how this behaviour is to be managed in both the short and long term. Handovers between wards and teams will clear and concise information regarding self-harming behaviours and risk reduction actions to be taken.

When developing this management plan consideration will be given to any advance directives which the patient may have in place.

Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including the assessment of risk, and should not be determined solely on the basis of having self-harmed. For people who have self-harmed and are deemed at risk of repetition, consideration may be given to offering an intensive therapeutic intervention including outreach services e.g. using a positive risk taking approach.

Where standardised risk assessment scales are used e.g. SADPERSONS (Appendix 2), to assess risk, they should only be used to identify those at high risk of repetition of self-harm or completed suicide. They should not be used as a means of excluding those viewed as low risk. All management plans should include review dates for risk assessments.

There are subtle differences in risk assessment processes between the adult and paediatric pathways;

- ***Paediatric patients*** will, at all times, be triaged/assessed in the A&E Dept. by a Registered Sick Children's Nurse and A&E Doctor. Referral will be made for Paediatric medical assessment.

- Paediatric and young people aged up to 19 years will automatically be admitted for assessment if they present to A&E having self-harmed. Only patients between 12 and 17 will have the Mental Health Assessment Tool used to assess she level of risk (appendix 1) individuals aged between 18 and 19 years will be assessed using the SADPERSON tool (appendix 2)

- The principles of Gillick competence should be applied to children aged 16 and under. Refer to the Trust Consent Policy for further information.

- Paediatric patients in the ward environment who require risk assessment will be assessed by a Registered Sick Children's Nurse and a Doctor with paediatric experience.

- The Children's and Mental Health Services (CAMHS) 24/7 pathway (appendix 3) will be used to inform the treatment plan in relation to onward referral for additional assessment.

- Health care workers should explore whether self-harming behaviour is linked to any form of abuse or vulnerability and make onward referral appropriately. This includes any concerns relating to children of parents or carers who self-harm.

- Refer to the separate policy, 'Children and Young People under the age of 16 Years who abscond/Go missing from the Paediatric Ward – Management of', for details of actions required if a child absconds from either the A&E Department or the Children and Young Persons Ward.

Adult patients must be considered to have capacity to consent to treatment unless proven otherwise. Staff often face difficult decisions about whether they should intervene to provide treatment and care to a person who has self-harmed and then refuses help. Not only are these decisions difficult but they can also provoke debates between staff who may interpret differently the legal framework that underpins them i.e. The Mental Capacity Act (2005).

A person may lack capacity to make the decision in question because of either long-term mental disability or because of temporary factors such as unconsciousness, confusion or the effects of fatigue, shock, pain, anxiety, anger, alcohol or drugs. If a person has capacity to make the decision, then this decision must be respected; even if a refusal may risk permanent injury or death to that person.

The concept of mental capacity is central to determining whether treatment and care can be given to a patient who refuses it. The Mental Capacity Act (2005) gives clear definition of capacity and "best interests", how to measure and record decisions and will not be dealt with explicitly within this policy. Staff should refer to the Mental Capacity Act 2005 Code of Practice for guidance.

Compulsory treatment can include medical and surgical treatment for the physical consequences of self-poisoning or self-injury if the self-poisoning or self-injury can be categorised as either the consequence of or a symptom of a patients mental health disorder, providing it can be shown (and recorded) that the patient lacks capacity and that the treatment satisfies the conditions of best interests as defined by the Mental Capacity Act (2005). All decisions regarding capacity assessment must be documented in the healthcare record.

- The SADPERSONS score system (appendix 2) will be used in both the A&E Department and ward environments to inform the treatment plan and guide onward referral for psychiatric review form the Crisis Team (appendix 4)

- Additional risk factors will be documented using the Trust Risk Assessment template.

- Contact details for onward referrals to Mental Health Services are available in both A&E Minors and Majors departments (appendix 5) and via switchboard.

- Older people (aged 65 and above) who self-harm should be considered as evidence of suicidal intent until proven otherwise.

- Health care workers should explore whether self-harming behaviour is linked to any form of abuse or vulnerability and make onward referral appropriately.

- Refer to the separate policy for actions required if an adult patient absconds from the A&E department.

- Special observation of the patient in the acute phase may be required. In A&E this will be the Secure Room unless deemed inappropriate. In the general ward environment the patient will be cared for in the most observable area however this will form part of the overall risk assessment.

It is important for staff to recognise that this is a therapeutic intervention that should involve the patient. It should not be carried out in a way that could be considered punitive. If instigated, special observations should be reviewed at prescribed periods so that they are carried out only for as long as is absolutely necessary. The management/care plan must clearly identify the conditions of observation e.g. continuous one-one. This must be escalated via the responsible Division to the Trust operational meetings. In no circumstances is it appropriate for special observations to the responsibility of relatives or friends. If restraint is considered appropriate to minimise or eliminate self-harm opportunities Trust policy must be followed including appropriate use of Mental Health section authorities.

3.1.2 Positive Risk Taking Approach

A positive risk-taking approach is person centred and focuses on developing the patient's strengths, and supporting them to take a higher level of control over the situation. In relation to patients who self-harm, positive risk taking could involve making a decision not to admit someone to an inpatient ward, or to discharge a patient who has had recent episodes of self-harm, because the risks of them being on a ward (e.g. an escalation in their self-harming) outweigh the risks posed if they are treated in the community. In these circumstances effective management of the short term risks could lead to longer term gains for the service user.

However due to the potential risks of such an approach any decision to proceed must be based on the patient having the capacity to engage in the agreed plan of care, and a detailed knowledge of:

- The patient's past history.
- Their current self-harming behaviour.
- The patient's ability to develop alternative coping mechanisms.

In such cases the multidisciplinary team, patient, and their relative or carers (subject to consent) should be involved in the decision, and in agreement with the plan of care.

All discussion which takes place is to be documented in the clinical records along with the details of who was involved. This also includes documenting any phone discussions which take place.

A detailed care plan is to be in place which includes contingency / crisis plans.

3.1.3 Environmental Assessment

All patients who present with self-harm will have a documented environmental risk completed as part of their care. The level of risk will determine the control measures required. For high risk situation this may include 1-1 supervision. In such cases resources will be identified to achieve this. All cases of 1-1 supervision must be escalated via the responsible Division to the Operational Centre.

Whilst it is difficult to eliminate all risks from clinical areas, environmental examination and assessment is required to identify potential and put in place mitigating actions that will minimise the risk of service users harming themselves whilst receiving care by having in place the following measures within high risk areas.

- Anti-ligature risk assessment (see appendix 6).
- Collapsible curtain tracking.
- Non barricade doors.
- Observation panels in doors.
- Controlled access/egress systems
- No access to implements/objects/chemicals etc. that could facilitate successful self-harm e.g. sharps, medications

These measures are also supported by the following Trust Policies and Procedures;

- Risk Assessment and Risk Assessment Policy
- Admissions Policy
- Patient Discharge Policy
- Patient Transfer Policy
- Missing Persons Guidance
- Restraint Policy

3.2 Patient & Carer Experience

People who have self-harmed should be treated with the same care, respect and privacy as any patient. Where ever possible patients should be included in decisions about their care and reference should be made to their personal choices and preferences. This should be documented in the healthcare record.

If a person has to wait for treatment or assessment, he or she should be offered an environment that is safe, supportive and minimises their distress. For many patients, this may be a separate quiet room with supervision to ensure safety.

Wherever possible, people who have self-harmed should be offered the choice of male or female worker. When this is not possible, the reasons should be explained and recorded in the notes. At all times appropriate chaperoning must be facilitated in accordance with Trust Policy.

When caring for people who repeatedly self-harm, staff should be aware that the individual's reason for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right.

When assessing people who self-harm, staff should ask patients to explain their feelings and understandings of the self-harm in their own words. Staff should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care.

Staff should ensure that the patient is kept fully informed of the different treatment options available. Where the patient has specific individual needs e.g. Learning Disability, sight or language difficulties information will be made available in a form that meets the patient's needs.

Local resolution i.e. at Ward level or with support from a Matron or Site Manager should always be attempted if a patient is not satisfied with the service they have received. Information regarding PALS and the complaints process should be available and provided if required.

The emotional support needs of relatives and/or carers will be considered as part of the patients care planning.

3.3 Discharge from Acute Care Services

When a patient who self-harms is discharged from the inpatient services, local discharge procedures should be followed including information to be provided to associated support services and relevant third parties e.g. GPs and any follow up arrangements with Mental Health or other services in accordance with individual patient need.

Advice should be sought from Mental Health support teams regarding individual patient information to be provided to help prevent repetition of self-harm events.

3.4 Reporting Incidents of Self Harm

All incidents of self-harm that occur whilst receiving care from Trust services will be reported via the Safeguard Incident Reporting System. All reports will prompt a review of the patient's current risk assessment and management plan. This will include triggers to individual self-harming behaviour.

The report system will be used enable trend analysis of self-harming incidents and occurrences.

3.5 Staff Training, Supervision and Support

All staff working with patients who self-harm (including children and young people) will receive training as part of their mandatory attendance at Mental Capacity Act (2005) education. Staff working in Emergency Departments should have documented records that they have received training to use the TOXBASE system.

Appendix 1 – Adolescent Mental Health Assessment Form/Risk Matrix

Accident & Emergency Department
ADOLESCENT (12-17 yrs)
Mental Health Assessment Form

Triage Questions

Name of person with Parental responsibility:……

Label

……

Relationship:……...

Accompanying Adult:……

Presenting Problem: ……

1. Background history and general observations	Yes	No
• Is the person currently aggressive and/or threatening?		
• Does the person pose an immediate risk to self, you or others?		
• Does he/she have specific ideas or plans to harm anyone else?		
• Does the person have any ***immediate*** (i.e.: within the next few minutes or hours) plans to harm self?		
• Is there any suggestion, or does it appear likely that the person may try and abscond?		
• Does he/she have a history of violence?		
• Has the person got a history of self-harm?		
• Does the person have a history of mental health problems or psychiatric illness?		
• Does the person appear to be experiencing any delusions or hallucinations?		
• Does the person feel controlled or influenced by external forces?		
If yes to any of the above, record details below:		

2. Appearance and behaviour	Yes	No
• Is the person obviously distressed, markedly anxious or highly aroused?		
• Is the person behaving inappropriately to the situation?		
• Is the person quiet and withdrawn?		
• Is the person attentive and co-operative?		
If yes to any of the above, record details below:		

- **Complete Missing Person I.D. Proforma ……..**
- **Check Child Protection Register ……..**
- **Order Hospital Notes ……..**

Triage Nurse …… Date……. Time……..

- **Rule out physical cause for the problem** ……
- **Check Epex/Care Plans for details of previous mental health history** ……
- **Is the person physically well enough (e.g.: not sedated, intoxicated, vomiting or in pain) to undertake a detailed interview with mental health staff?** ……

3. History

- Why is the person presenting now? Give details below:

- What recent event(s) precipitated or triggered this presentation? Give details below:

- What is the person's level of social support (i.e.: school, employment, social worker, family members, friends)?

Give brief details below:

4. Suicide risk screen - greater number of positive responses suggests greater level of risk

	yes	no	d/k		yes	no	d/k
History of bullying	☐	☐	☐	Family psychiatric history	☐	☐	☐
Previous self-harm	☐	☐	☐	Family history of suicide	☐	☐	☐
Previous use of violent methods	☐	☐	☐	Unemployed (over 16)	☐	☐	☐
Suicide plan/expressed intent	☐	☐	☐	Male gender	☐	☐	☐
Current suicidal thoughts/ideation	☐	☐	☐	Hopelessness/helplessness	☐	☐	☐
Poor social support	☐	☐	☐	Depression	☐	☐	☐
Family concerned about risk	☐	☐	☐	Evidence of psychosis	☐	☐	☐
Disengaged from services	☐	☐	☐	Alcohol and/or drug misuse	☐	☐	☐
Poor adherence to psychiatric Tx	☐	☐	☐	Chronic physical illness/pain	☐	☐	☐
Access to lethal means of harm	☐	☐	☐				

Formulation of assessment
Refer to the risk assessment matrix and summarise:

- What is the key problem?
- What is the level of risk – e.g.: low, medium, high, very high?
- Is referral to the CAMHS indicated?

Summary of assessment and initial risk screen:	
Low **Medium** **High** **Very High**	**What category of overall risk do you think most applies to this patient?**
Medical Management:	
Action plan and outcomes: If referring to CAMHS please indicate nature of request e.g. assessment – urgent/routine, for information only, community services	

Has patient or parent consented to CAMHS Referral? **YES** **NO**

How should patient or parent be contacted……

Signed: …… **Designation:** ……

Print Name: …… **Date:** ……..

Form Faxed to CAMHS ☐ **YES** ☐ **NO**

Mental Health Assessment Risk Assessment Matrix			
Level of risk	**Key risk factors**	**Action**	**Timescale**
Low Risk	▪ Minor mental health problems may be present but no thoughts or plans regarding risk behaviours to self or others, or unlikely to act upon them; ▪ No evidence of immediate or short-term risk or vulnerability.	▪ Treatment and follow up arrangements managed by A&E team. ▪ Referral to primary care services. GP/School Nurse. ▪ May benefit from mental health advice e.g. safe alcohol consumption or non-statutory counselling services etc.	▪ **Immediate referral to CAMHS not necessary.** ▪ **Inform G.P. of attendance** ▪ **If patient known to Social Services – Please inform Duty Social Worker**
Medium Risk	▪ Mental health problems present and/or have non-specific ideas or plans regarding risk behaviours to self or others. ▪ These either not dangerous or no plans to act upon them. ▪ Potentially vulnerable in certain circumstances. ▪ Attempted suicide, but no longer suicidal	▪ Should have specialist mental health assessment from CAMHS ▪ Should be advised to seek further help if necessary e.g. from GP ▪ GP to be informed as well as CAMHS if already known.	▪ **If attempted suicide and under 16 admit under paediatric team** ▪ **If attempted suicide age 16, discuss with CAMHS duty clinician: 9-5 Tel: 220300** **out of hours Tel: 329000** ▪ **Other cases:** **Fax Assessment Form to CAMHS to request outpatient appointment within 7 days – with consent (01473 280809)** **All 17 years + Refer to CRHTT** **Fax form to: 01473 329802** **Phone: 07973234508**
High Risk	▪ Serious mental health problems present, including possible psychotic features; ▪ And/or has clear ideas or plans regarding risk behaviours to self or others. ▪ Attempted suicide and still suicidal or uncertain ▪ Mental state may deteriorate if left untreated and potentially vulnerable.	▪ Urgent mental health assessment from CAMHS required and an action plan to be drawn up to address immediate and short term risk factors. ▪ Key clinicians/others likely to be involved should be informed.	**As for medium risk +** ▪ **Attempts should be made to stop patient leaving department before mental health assessment.** ▪ **Police to be informed if patient absconds.** ▪ **Inform duty child care social worker**
Very High Risk	▪ Serious mental health problems present, including possible psychotic features; ▪ And/or has strong and immediate plans or ideas regarding risk behaviours to self or others. ▪ May have already self harmed. ▪ Mental state likely to deteriorate if left untreated. ▪ Almost certainly vulnerable.	▪ Immediate action needed, including urgent mental health assessment from CAHMS. ▪ Action plan addressing immediate and short term risk factors, including an ongoing treatment and care package. ▪ If patient is not willing to engage, a Mental Health Act assessment should be arranged before person leaves the Department.	▪ **As for High Risk +** ▪ **Inform Duty Approved Social Worker**

Appendix 2 - SADPERSON Score Assessment Form

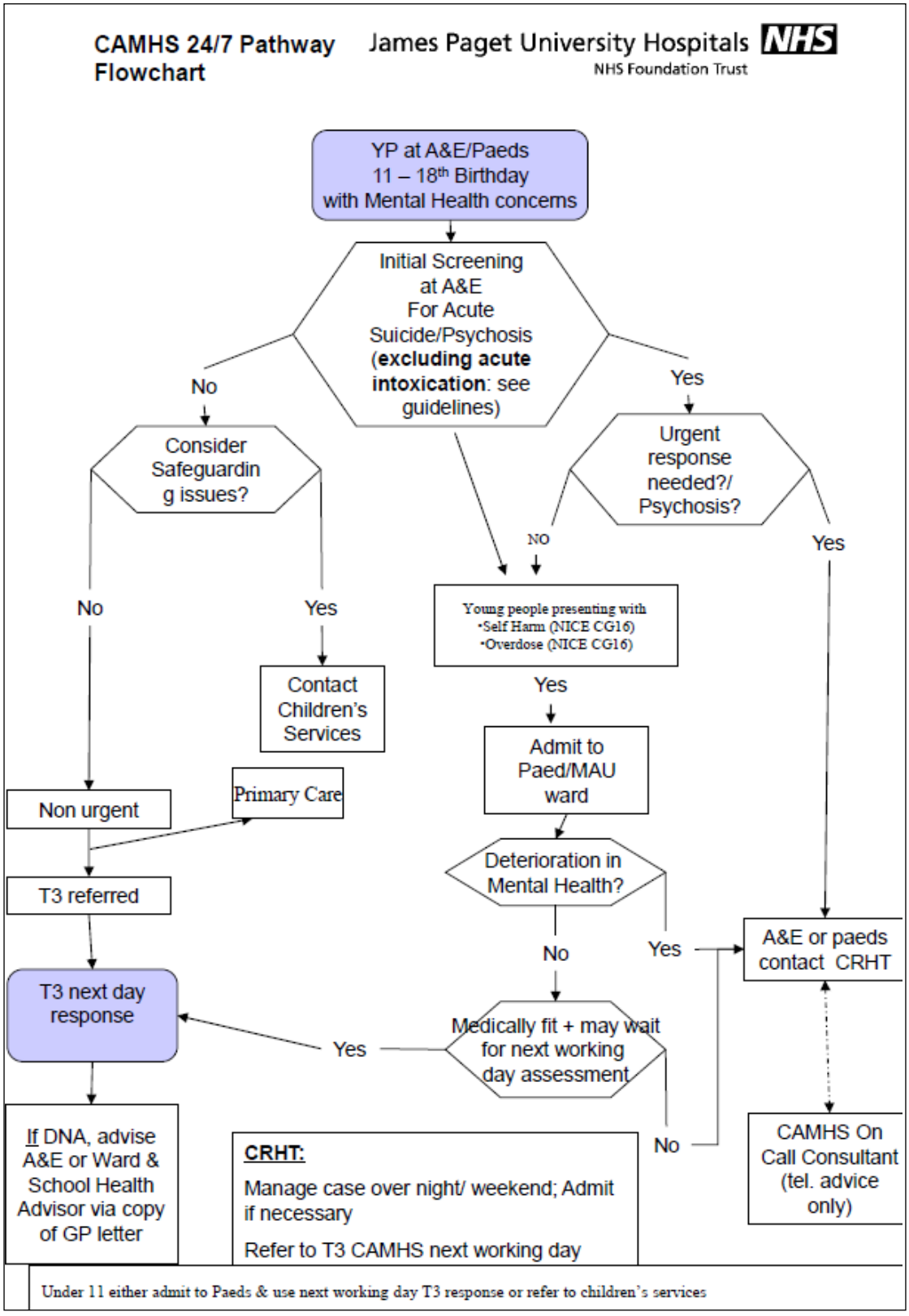
SADPERSONS Score

- **S: Male sex**
- **A: Older age**
- **D: Depression or hopelessness**
- **P: Previous attempt**
- **E: Ethanol or drug abuse**
- **R: Rational thinking loss**
- **S: Social supports lacking**
- **O: Organised plan**
- **N: No spouse**
- **S: Sickness or Stated future intent**

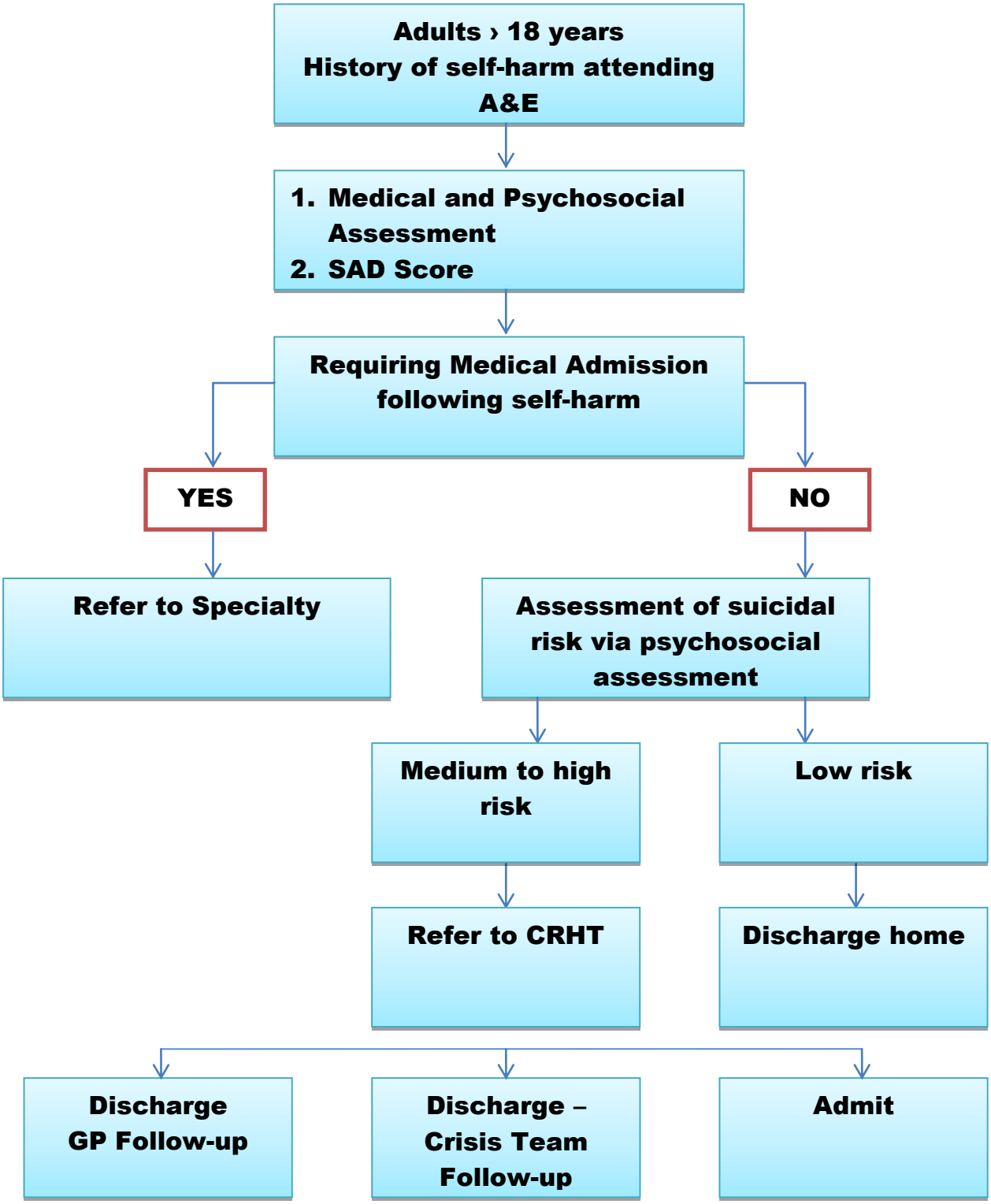
1 Point for each of above

- **0-5: May be safe to discharge (depending upon circumstances)**
- **6-8: Probably requires psychiatric consultation**
- **>8: Probably requires hospital admission**

Appendix 3 – Children and Adolescent Mental Health Services (CAMHS 24/7) Pathway



Appendix 4 - Adult 24/7 Flow chart



Appendix 5 – Referral Contact Details

Self-Harm Contact Numbers

1. **Children requiring referral to the Children and Adolescent Mental Health Services (CAMHS will see up to the 18th birthday office hours)**

   - Lowestoft Child and Family Centre 01502 533500
   - Great Yarmouth, Silverwood Centre 01493 337601

2. **Children and Adults requiring referral for Self-harm**

   - Access and Assessment Team (24 hour service for all referrals)

     07919 016716

(April 2013)

Appendix 6 - Examples of ligature points for inclusion in the Environmental Risk Assessment

- Bed cubicle curtain tracking
- Window curtain tracking
- Shower rails
- Suspended ceilings where ceiling tiles can be lifted
- Shower heads
- Pipe work (boxed in)
- Wardrobe rails
- Wardrobe hinges
- Door closures
- Door handles
- Door hinges
- Windows
- Bed head lights
- Taps
- Pillowcases – all should have non permeable covers
- Sheets
- Coat hooks

Appendix 7 - Equality Impact Assessment

Policy or function being assessed: Self Harm Management Policy
Department/Service: Trust wide
Assessment completed by: Jacky Copping, Deputy Director of Nursing
Date of assessment: 5th June 2013

1.	Describe the aim, objective and purpose of this policy or function.			
2i.	Who is intended to benefit from the policy or function?		**Staff** √ **Patients** √ **Public** □ **Organisation** √	
2ii	How are they likely to benefit?		• Staff will have direction to support practice relating to patients who self-harm • Patients will receive safe, effective and timely care delivery • The organisation will have assurance that systems and processes are in place to manage the risks associated with patients self-harm	
	What outcomes are wanted from this policy or function?		All patients presenting to the Trust requiring care related to self-harm and associated suicide risk will receive individualised care using a risk based approach using national guidance and current best practice, and in accordance with this policy.	
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:				
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical, Mental and Social disabilities (e.g. Learning Disability or Autism).		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **marriage or civil partnership?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
14.	**Specific Issues Identified**			
	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment			Page/paragraph/section of policy/function that the issue relates to
	1. NA			**1.**
	2. NA			**2**
	3. NA			**3**

15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?	**NA**	
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?	**N/A**	
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/ redrafted?		**NO**
17.	**Policy/Function Implementation**		
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service:** Tina Cookson **Title:** Director of Nursing **Date:** 6th June 2013 **Name of Policy/function Author:** Justine Goodwin / Jacky Copping **Title:** Sister / Deputy Director of Nursing **Date:** 6th June 2013 (A paper copy of the EIA which has been signed is available on request).		
18.	**Proposed Date for Policy/Function Review**		
	Please detail the date for policy/function review (3 yearly): June 2016		
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the Trust's website).*		
	Standard Trust process, Intranet, Patient Safety Committee, Health and Safety Committee,		

20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures. They are that all staff intend to do their best by: Putting patients first, and they will: Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. Aiming to get it right, and they will: Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services Recognising that everyone counts, and they will: Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. Doing everything openly and honestly, and they will: Be clear about what they are trying to achieve, Share information appropriately and effectively, Admit to and learn from mistakes. I confirm that this policy/function does not conflict with these values. ☑

James Paget University Hospitals NHS
NHS Foundation Trust

Policy and Procedure for Enhanced Supervision of Patients at Risk of Harm

Document Control:

Document Author:	**Matron, Learning Disability Liaison Nurse**		
Document Owner:	**Document Review Group**		
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Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

EXECUTIVE SUMMARY

As our core business there is a legal and regulatory requirement to demonstrate that patient care is safe and effective. There are many variables that influence our ability to consistently achieve this within business as usual principles and this includes the management of patents who are at risk of harm if left unsupervised. This policy and procedure describes the framework to be used to ensure that robust risk assessment takes place, appropriate resource management is employed and care plans are tailored to the specific needs of patients in order to;

- to prevent harm to a patient or others as a result of the patient's challenging behaviour
- to prevent harm to a patient who has a cognitive impairment that limits or removes their understanding of personal safety and, who constantly attempts to walk independently
- to prevent harm to a patient who has a cognitive impairment that limits or removes their understanding of personal safety and, who constantly attempts to get out of bed independently

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CONTENTS

1 INTRODUCTION

As a public authority we have a legal requirement under the Equality Act 2010 legislation to promote equality for people with characteristics protected by the act, these being age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Furthermore the Department of Health provides clear guidance to Managers of health services who have responsibilities for the safety and well-being of all their patients, in particular, the duties for those patients who are less able to protect themselves from harm, neglect or abuse, for example, due to impaired mental capacity or cognitive impairment. Similarly the National Dementia Strategy (DOH, 2009) clearly identifies the specific and unique needs of persons living with dementia which include adaptations for behavioural and psychological symptoms including wandering and challenging behaviours.

1.1 Background

Increasingly the James Paget University Hospital wards are faced with the challenges of providing adequate levels of care to maintain the safety of patients who present with diverse or challenging behaviours. In some circumstances there are already defined processes in place to safety and effectively safeguard such individuals from harmful situations. This is achieved through robust risk assessment that helps to inform actions to mitigate the risks required to protect staff and patients from harm.

There are a number of circumstances where this would be appropriate for adult patients:

- the patient is at risk of self-harm and/or presents a risk to others.
- the patient is likely to abscond from the ward and is at risk to him/herself
- the patient is confused/agitated/aggressive/violent towards others
- the patient has a history of falls or assessed as at high risk of falling
- the patient has Autism/Learning Disabilities/Dementia
- any person of any age who has a confusional state that may be acute or chronic may be at risk of wandering.

1.2 Scope

The Trust recognises its obligations to constantly assess the needs of patients in a manner that supports the maintenance of their safety and wellbeing. This policy is intended for use by all members of the multidisciplinary team who have direct contact with patients across all inpatient areas and who are responsible for ensuring risks to patient safety are assessed, mitigated and where appropriate escalated.

This document includes;

- patients who meet the criteria for enhanced supervision using the trusts risk assessment processes (appendix 1)
- patients admitted to hospital in the knowledge that enhanced supervision will be required e.g. an individual living with Learning Disabilities or Dementia

The document does not include patients under the age of 18.

1.3 Responsibilities

Maintaining patient safety is a legal and externally regulated requirement. The Trust Board has overall responsibility for providing assurance that patients are safe in our care and that this policy meets that obligation.

All Clinical and Operational Managers, Senior Sisters/Charge Nurses, Matrons, Clinical Directors & Heads of Departments have delegated responsibility to implement and monitor the effectiveness of the policy actions. This includes putting mechanisms are in place to ensure that all relevant team members are aware of this policy and the procedures to be followed which will ensure risks to patient safety and experience are appropriately assessed and mitigated and where full mitigation is not possible escalation takes place.

1. 3.1 Sister/Charge Nurse/Shift Coordinator

Where the Sister/Charge Nurse/Shift Leader has identified that a patient may require enhanced supervision she/he will complete an individual risk assessment taking into account the following factors;

- staffing establishment
- skill mix (consider what competencies/skills are required to care for the patient safely)
- current patient acuity on the ward
- the patient risk to themselves or others patients/staff/visitors
- identify alternative strategies and controls to manage the individual patient's safety as potential solutions prior to putting one to one enhanced supervision in place
- consider moving the patient to a visible area
- consider asking the carer / relative if they are able to be with the patient
- escalate concerns to the Matron or Site Manager
- complete a risk assessment and represent at next operational meeting
- provide specific documented guidance for care of this patient via the nursing and multidisciplinary care and treatment plans
- ensure that the members of staff providing enhanced supervision receive a full report on the patient's condition, the reason(s) for this level of care including a summary of concerns and risk factors
- ensure cover for breaks are provided to the staff member providing enhanced observation and / or rotate staff to ensure appropriate levels of observation are achieved at all times
- ensure that as far as is practicable that the patient understands why enhanced supervision is in place. If the patient doesn't have capacity family/carers must be included and kept informed of the care plan

1.3.2 Individuals Providing Enhanced Supervision

Individuals providing enhanced supervision have a key role in supporting patient safety and wellbeing. Their responsibilities whist performing this role are to;

- ensure they receive and understand the patients care plan and individual care needs
- monitor the patients activities and evaluate the care plan throughout the shift/period of enhanced supervision
- document care delivery, where relevant and role appropriate reassess the patients need and amend care plans accordingly

- escalate any concerns that impact on the ability to maintain the patients safety
- report any adverse incidents using the Safeguard Incident reporting system.
- access support and assistance from other members of the team as required
- assist with other patient care as required where it has been risk assessed safe to do so
- provide assistance with suitable activities e.g. jigsaws, crosswords, reading

1.3.3 Matron / Site Manager responsibilities

The Matron / Site Manager will:

- where requested by a Sister/Charge Nurse/Shift Coordinator review a request for enhanced supervision and assess whether additional staffing is required
- if required support the Sister/Charge Nurse/shift coordinator to conduct a daily review of risk assessments, taking into consideration any changes in the patient's condition and behaviour and the impact this has on patient safety and staffing requirements
- represent the outcome of risk assessments at operational bed meetings including the impact on the ward/Divisions ability to provide safe and effective care

1.4 Monitoring and Review

Monitoring and review of this policy will be a Divisional responsibility. Quarterly reviews will take place to inform the following;

- volume of patients requiring enhanced supervision
- analysis of risk assessment forms;
    - volume of enhanced supervision, ward by ward
    - reasons for enhanced supervision, ward by ward
    - method of providing enhanced supervision e.g. CNB, overtime
- harm incidents relating to patients who have received enhanced supervision
- number of shifts not covered for enhanced supervision purposes

Analysis outcomes will form part of Divisional reporting to the Patient Safety Committee.

1.5 Related Documents

- Mental Capacity Act 2005

- Dewing, J. (2005) Screening for wandering among older persons with dementia. Nursing Older People; 17, 3: page 20 – 24.

- Folstein, M, F., Folstein, S, E. & McHugh, P, R. (1975) "Mini-Mental State: A Practical Method for Grading Cognitive State for Patients for the Clinician." Journal Psychiatric Research. 12: 196-8,

- www.wanderingnetwork.co.ok

- Living Well with Dementia – A National Dementia Strategy, Department of Health 2007

- Safeguarding Adults, Department of Health 2011
- Adult Slips, Trips and Falls Prevention and Management Policy, JPUH
- Safeguarding Adults (Vulnerable Adults in need of Protection), JPUH

1.6 Reader Panel

The following formed the Reader Panel that reviewed this document:

Post Title
Learning Disability Acute Liaison Nurse
Matron Emergency Division
Integrated Dementia Project Lead
Deputy Director of Nursing, Quality & Safety
NSFT Mental Health Act Lead

1.7 Trust Values

This Policy conforms to the Trust's values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

1.8 Glossary

The following terms and abbreviations have been used within this Policy:

Term	Definition

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

2.0 STATEMENT OF POLICY

To provide a framework that facilitates appropriate and relevant risk management and decision making regarding the instigation of enhanced supervision for patient who may experience harm without. This includes:

- to prevent harm to a patient or others as a result of the patient's challenging behaviour
- to prevent harm to a patient who has a cognitive impairment that limits or removes their understanding of personal safety and, who constantly attempts to walk independently
- to prevent harm to a patient who has a cognitive impairment that limits or removes their understanding of personal safety and, who constantly attempts to get out of bed independently

2.1 Policy Objectives

The objective of the Policy is to:

- embed and sustain the use of a risk based approach to inform decisions regarding the care planning for patients requiring enhanced supervision to maintain their safety
- provide a framework of to ensure all required control measures are considered and implemented to maintain patient safety, including documented evidence of care plan assessment, planning, implementation and evaluation
- embed and sustain a process of escalation when safe delivery of care is at risk
- use operational meetings as the central hub for escalating concerns and providing assurance that risks have been assessed and mitigation considered
- adjust staffing levels accordingly (including redeployment from other inpatient / outpatient areas)
- reduce incidence of harm to patients who require enhanced supervision

2.2 Policy Definitions

- Enhanced Supervision – a control measure put in place to increase the close presence of healthcare workers for patients who are at increased risk of harm if left unsupervised
- Harm - (for the purposes of this policy) an injury/insult caused by healthcare management (system or human) rather than the underlying disease or condition of the patient. Different levels of harm exist.
- Risk Assessment – an examination of what could cause harm and consideration od what actions/precautions are required to prevent harm occurring
- Mitigating Actions – actions taken to lessen the likelihood and consequence of a risk ie patient/staff harm

3.0 Details Section

3.1 Care Plan Considerations

The following factors must be considered as part of a patient's care plan;

- Wandering should only be prevented where there are high level safety risks and the person does not respond to diversion or distraction and regularly or constantly seeks to leave the designated clinical area. Consider the following factors;
    - Does the patient have a history of being a regular walker either as a hobby or as part of their daily life?
    - Has the patient regularly used walking as a coping mechanism?
    - Does the person have an outgoing or sociable personality?
    - Has the patient recently moved home or moved within a care setting?
    - Does the patient usually wander at home?
    - Has the patient tried to leave a place of safety in the past?
    - What is the time of day that wandering occurs?

- Wandering should only be contained where the environment is an actual risk for the person or if the person is becoming distressed, exhausted or their health is adversely effected.

- The presence of delirium must be assessed, be ruled out and/ or reversed

- Ensure a baseline cognitive assessment has been performed and documented, in most instances this will be the 'Abbreviated Mental Test Score (AMTS)' or the 'Mini-Mental State Examination (MMSE)

- Consider the input of specialist team members e.g. Dementia Care Liaison Nurse, Learning Disability Acute Liaison Nurse

- A falls prevention risk assessment must take place on admission, every seven days or if the patients clinical condition changes. Preventative actions can be found in the Essential Assessment and Care Planning Booklet.

- Ensure the person is wearing a correct identity band and appropriately dressed to ensure dignity. This includes well-fitting footwear.

- Patients at risk of wandering should be nursed in a high observation area within the Ward area where possible & ensure they are placed away from main thoroughfares and exits and that ward door security alarms or locks are used where fitted.

- If the patient is sensitive to over stimulation from noise and light levels, then consider a quieter area

- Ensure Ward doors are always closed; such a physical barrier can simply prevent wandering out of a clinical area.

- Provide appropriate signs and cues (words and/or pictures) for orientation purposes including personal photos & clocks to identify personal bed space and the toilets.

- Use the intentional rounding process to check for causes of physical discomfort such as hunger, thirst, pain and desire to go to the toilet.

- Negotiate with family or volunteers to provide companionship. This may be during busy periods for staff or at the times when the patient's behavioural pattern is known to change.

- Consider commissioning of specialist carers e.g. Learning Disabilities.

- Ensure the person has an escort if leaving the ward area for investigations or treatment outside of the main care environment.

- Where possible accompany the person whilst they wander/walk, this will reassure the person making them feel more at home in our environment and less likely to leave. If you can accompany the person for a longer walk so they can leave the ward or department for a short time this can be beneficial.

- If a patient goes missing from the clinical area please refer follow guidance for missing persons

3.2 Use of Assistive technology

If the patient has been identified through the Screening tool to have the potential to undertake a more risky type of wandering and or has made an attempt to leave/wander from the ward, then staff can consider the use of assistive technology such as pressure pad alarm sensors. Assistive technology where available for use, should only be used in a therapeutic manner, in extra-ordinary circumstances in order to maintain patient safety and promote safer wandering.

Where possible the patient's consent should be sought for the use of these devices. If a person lacks capacity to make this decision the practitioner must take into account the views of anyone named by the person as someone to be consulted and/or anyone engaged in caring for the person interested in their welfare. The practitioner should also consider the use of an Independent Mental Capacity Advocate (IMCA) if there is nobody to advocate for the patient.

Appendix A - Risk Assessment – Enhanced Supervision for Patients at Risk of Harm

Name of Patient	Ward	Risk Category A B C	Supervision Required 1:1 **Day**				Supervision Required 1:1 **Night**		1:1 Supervision Achieved by – • CNB • Overtime • No increase in establishment required	Comments
			Early		Late		Yes	No		
			Yes	No	Yes	No				

Completed by - Name…….. Role……

Date…….. Time…….

Risks identified indicating need for enhanced supervision

A - To prevent harm to a patient or others (patients or staff) as a result of the patients challenging behaviour

B - To prevent harm to a patient who has a cognitive impairment that limits or removes their understanding of personal safety and, who constantly attempts to walk independently

C - To prevent harm to a patient who has a cognitive impairment that limits or removes their understanding of personal safety and, who constantly attempts to get out of bed independently

Appendix 2 - Equality Impact Assessment

Policy or function being assessed: Policy and Procedure for Enhanced Supervision of Patient's at Risk of Harm **Department/Service:** Corporate
Assessment completed by: Sarah Plume, Matron Emergency Division **Date of assessment:** 26/02/2014

1.	Describe the aim, objective and purpose of this policy or function.	To provide enhanced patient supervision to those patients at risk of self-harm and/or who presents a risk to others.		
2i.	Who is intended to benefit from the policy or function?	**Staff X** **Patients X** **Public ☐** **Organisation X**		
2ii	How are they likely to benefit?	To provide a safe environment that is suitable for all patients that may have cognitive impairment whether permanent or temporary		
2iii	What outcomes are wanted from this policy or function?	To provide a framework to deliver harm free care and support decision making		
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:				
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical, Mental and Social disabilities (e.g. Learning Disability or Autism).		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **marriage or civil partnership?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
14.	**Specific Issues Identified**			
	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment			Page/paragraph/section of policy/function that the issue relates to
	1.			**1.**
	2.			**2**

	3.		**3**
15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?		
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?	**Y**	**N**
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted?	**Y**	**N**
17.	**Policy/Function Implementation**		
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service:** Elizabeth Libiszewski **Title:** Director of Nursing, Quality and Patient Experience **Date:** 26.02.2014 **Name of Policy/function Author:** Rebecca Crossley & Sarah Plume **Title:** Learning Disabilities Acute Liaison Nurse **Date:** 26.02.2014 (A paper copy of the EIA which has been signed is available on request).		
18.	**Proposed Date for Policy/Function Review** 02/2014		
	Please detail the date for policy/function review (3 yearly): 02/2017		
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the*		

	Trust's website).
	Standard Trust process
20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures. They are that all staff intend to do their best by: Putting patients first, and they will: Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. Aiming to get it right, and they will: Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services Recognising that everyone counts, and they will: Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. Doing everything openly and honestly, and they will: Be clear about what they are trying to achieve, Share information appropriately and effectively, Admit to and learn from mistakes. I confirm that this policy/function does not conflict with these values. ☑